



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Nicolau J. Chamma, MD

Respondent Name

American Zurich Insurance Company

MFDR Tracking Number

M4-15-0447-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

October 1, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We submitted a request for reconsideration to Fara Houston on 08/22/2014, this request was in response to a \$300.00 reduction of the \$2050.00 for the Designated Doctor Exam performed on 05/30/2014. Unfortunately our request was denied and we are seeking the balance owed to us.

The denial reason(s) per EOB are: Workers Compensation fee schedule adjustment. Designated Doctor Exams are billed according to DWC rule 134.204 and in accordance with labor code 408.004, 408.0041, and 408.151."

Amount in Dispute: \$300.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on October 9, 2014. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

Response Submitted by: NA

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 30, 2014	Designated Doctor Examination	\$300.00	\$300.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the procedures for billing and reimbursing Designated Doctor Examinations.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - P12 – Workers’ compensation jurisdictional fee schedule adjustment.
 - 18 – Exact duplicate claim/service

Issues

1. What is the total allowable for the services in question?
2. Is the requestor entitled to additional reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.204 (j)(3), “The following applies for billing and reimbursement of an MMI evaluation. (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be \$350.” The submitted documentation indicates that the Designated Doctor performed an evaluation of Maximum Medical Improvement as ordered by the Division. Therefore, the total allowable for this examination is \$350.00.

This dispute involves a Designated Doctor Impairment Rating (IR) evaluation, with reimbursement subject to the provisions of 28 Texas Administrative Code §134.204(j)(4), which states that “(C) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas. (i) Musculoskeletal body areas are defined as follows: (I) spine and pelvis; (II) upper extremities and hands; and, (III) lower extremities (including feet). (ii) The MAR for musculoskeletal body areas shall be as follows... (II) If full physical evaluation, with range of motion, is performed: (-a-) \$300 for the first musculoskeletal body area; and (-b-) \$150 for each additional musculoskeletal body area. (D) ... (i) Non-musculoskeletal body areas are defined as follows: (I) body systems; (II) body structures (including skin); and, (III) mental and behavioral disorders. (ii) For a complete list of body system and body structure non-musculoskeletal body areas, refer to the appropriate AMA Guides... (v) The MAR for the assignment of an IR in a non-musculoskeletal body area shall be \$150”.

Review of the submitted documentation finds that the requestor performed Impairment Rating evaluations with a full physical examination and range of motion for the cervical spine and left knee. The documents also support that the requestor performed impairment evaluations of the eye, ear and face, and behavioral conditions. The AMA Guides to the Evaluation of Permanent Impairment (fourth edition) places the eyes in the Visual System chapter. For this reason, it is considered a body system in the non-musculoskeletal category. The AMA Guides to the Evaluation of Permanent Impairment (fourth edition) places the ear and face in the Ear, Nose, Throat, and Related Structures chapter. For this reason, it is considered a body structure in the non-musculoskeletal category. Therefore, the total allowable for the examination to determine Impairment Rating is \$900.00. See the table below for a detailed analysis.

Examination	§134.204 Category	Reimbursement Amount
Maximum Medical Improvement		\$350.00
IR: Cervical (ROM)	Spine & Pelvis	\$300.00
IR: Left Knee (ROM)	Lower Extremities	\$150.00
IR: Left Eye	Body Systems	\$150.00
IR: Left Ear and Face	Body Structures	\$150.00
IR: Behavioral Conditions	Mental & Behavioral Disorders	\$150.00
Total MMI		\$350.00
Total IR		\$900.00
Total Exam		\$1,250.00

2. Review of the submitted documentation finds that the total allowable for disputed CPT Code 99456 W5 WP is \$1250.00. The insurance carrier paid \$950.00. Therefore, the requestor is entitled to an additional reimbursement of \$300.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$300.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$300.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

January 27, 2015
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.